

# Better Homes and Centers



Michigan Department of  
Social Services

Health Practices

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## PASSING MEDICATIONS

*By Richard J. Sagall, M.D.  
Family Practitioner  
Bangor, Maine*

It's not uncommon for a sick child to return to day care with a bottle of medicine that needs to be taken during the day. The child is healthy enough to be back but still needs medicine. How do you handle this situation? What type of training is necessary? What precautions should you take to protect the health of the child? And what's your liability? In order to answer these questions, you need to know something about drugs.

### Type of Treatments

Most drugs your children take will fall into two classes: treatment for an acute problem or treatment for a chronic illness. The first category includes infections such as otitis media (ear infections), strep throat, cystitis (bladder infections), and skin infections. These drugs are needed for a short and finite time, most often ten to fourteen days. Missing a dose probably won't cause any severe problems. Illness such as epilepsy, diabetes, and asthma fall into the second category. Treatment of these problems may last for years. Missing a dose may cause severe problems that might occur quickly.

### Types of Medicines

Most young children are given the liquid form of a medicine. It has the obvious advantage of being easier to give. Most are bubble-gum-flavored, a taste that's almost universally liked by children. Often children will anxiously await their next dose. The dose is usually measured in teaspoons, although you may encounter a drug dose listed in cubic centimeters. One teaspoon is the equivalent of five cubic centimeters (cc). Unfortunately, not all teaspoons are 5 cc; they vary from 3 cc to 8 cc. A measuring teaspoon is 5 cc and should always be used.

How accurate do you have to be in measuring out a dose? Should you be concerned if some of the medicine runs down a child's chin or is spit up? Usually it doesn't make too much difference. Most drug dosage calculations are approximations. It's hard enough to get one teaspoon into a child, let alone worry about three

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## DIRECTOR'S CORNER

The State of Michigan, for whatever the reason, is facing a most serious budget crisis. The Legislature has passed a bill which requires the State Departments, including the Department of Social Services, to reduce their budgets by 9.2%. The Legislature will ultimately receive a plan from the Governor's office early in 1991 for its review and approval. One of the budget reduction options that is being proposed is the elimination of Child Day Care Licensing. This would include the regulation of child care centers, group day care homes and family day care homes. Should the elimination of licensing occur, over 17,000 child day care facilities serving over 225,000 children will go unregulated. Along with the elimination of licensing, is a potential loss of child care food monies as well as other Federal dollars, e.g., Head Start and Child Care Development Block Grant.

No regulation would mean that virtually anyone who wishes to provide child care in literally any setting can do so without regard for staffing, fire safety, environmental health, or any other program expectations. The potential for warehousing of children means reduced overhead costs, cut-rate bargains and unfair competition to those who wish to provide care in a safe and developmentally appropriate manner. While for many of you, the elimination of Child Day Care Licensing is inconceivable, I cannot emphasize to you enough the seriousness of the fiscal problems facing Michigan at this very moment. Governor John Engler and the Legislature must make some very difficult decisions as they contemplate which programs to cut and which ones should remain. Furthermore they must do so with minimal delay. To do otherwise would only compound the problem in the months to come.

I share this information with you because you have a right to know what options are being considered. For some of you this may be good news and for others, bad news. In any event, if you, your staff, or your parents have concerns or opinions regarding the elimination of Child Day Care Licensing, they should be shared with those who will ultimately be making the decisions regarding this program.

Ted deWolf, Director  
Division of Child Day Care Licensing

## Passing Medications

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quarters or two-thirds of a teaspoon. If a child vomits shortly after taking a dose, it probably can be repeated with little risk of problems.

Many drugs now come in a chewable form. These are much easier to give than a liquid. There's no measuring of the dose, and most children are willing to take them without a hassle.

Tablets and capsules can be the hardest for children to take. It's rare for children under seven or eight to have the coordination or willingness to swallow a pill.

Some capsules are designed to be opened, with their contents sprinkled on food. It's rare for problems to occur if a child's medicine can be given this way. Capsules shouldn't be opened without an OK from the doctor or pharmacist.

Eye drops and ointments are almost always a losing battle. Tricks for getting eye medicines into little eyes abound, but none are foolproof. Probably the best way to get drops and ointments into a child's eye is to ask the child's parent what works best and use the same technique.

### Instructions

For a medicine to be effective, it must be given properly. To give it properly, you first must know how it should be given. It's best not to take a parent's word on the dosage and timing; sometimes misunderstandings happen. The instructions should be on the medicine container's label. If a parent says the doctor changed the instructions, get the new instructions in writing from the doctor. Don't give medicines without written instructions.

Another reason to demand that the pills or liquid be in their original container is to ensure the medicine is what it's supposed to be. A parent, rushing to get out of the house, may grab the wrong bottle. Never give medicines from an unlabeled bottle. If the medicine is needed for a long time, you should ask the parent to get a special bottle that can be left with you.

### Reactions

Anyone may have a reaction to any medicine at any time. Just because a child has taken a drug many times doesn't mean he or she won't have a reaction with the next dose. This means every cold needs to be watched after taking a dose of any medication.

The most common reactions are skin rashes. Usually they are mild, primarily causing itching and welts. Other drugs may cause a fine rash that covers the child's entire body. Complaints of difficulty breathing or swallowing may indicate that a serious problem is developing. Younger children may not complain but may exhibit symptoms such as sudden drooling or panting. If these problems develop, the child needs to be seen by a doctor immediately.

### Side Effects

Side effects may occur with any medicine. Most are

relatively minor and don't necessitate stopping the medicine. Since the majority of medicines pass through the stomach, this part of the body is most likely to be affected. Diarrhea and an upset stomach are common side effects, particularly with antibiotics. Drowsiness can occur, although it's not common with pediatric medicines.

### Food

Food can affect the absorption of medicine. Some drugs should be given with food to increase absorption or lessen side effects. Food can interfere with the absorption of other drugs. Often the bottle will be labeled with instructions concerning food. If in doubt, contact the pharmacist.

### Giving Medicines

It's important to have clear policies about medicines in the day care setting. What training is necessary to give medicine properly? You don't need a nurse to do it, but some instruction is important. If you have a consulting physician or nurse, they can help establish policies.

Here are a few suggestions:

- The person who gives the medicine should be the one who gets the drugs from the parent.
- The instructions should be written down, not taken verbally.
- Find out if the child has had any problems with the medicine.
- The medicine must be in the original bottle.
- Ask the parent if there are any special tricks you should know about.
- Ask the parent for exact times to give the medicine.
- If it's during naptime, should you awaken the child?
- If the child were to have a reaction to the medicine, where should she or he be taken for treatment? (Do you have written consent for emergency treatment?)
- If you have problems or questions, how can you get in contact with the parent?
- Have a locked cabinet for storing medicines.

With proper planning before a child appears with a bottle of medicine, you can provide a safe environment for giving children medicine.

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# TAKE APPROPRIATE ACTION WHEN A CHILD WITH SYMPTOMS OF ILLNESS HAS BEEN IDENTIFIED

These are important symptoms of illness to look for among children in day care.

## • **DIARRHEA**

This means more than one abnormally loose stool. If a child has just one loose stool, he may have diarrhea. Observe the child for additional loose stools or other symptoms. Be sure that the child and his caregivers wash their hands at all recommended times.

## • **SEVERE COUGHING**

Child gets red or blue in the face.  
Child makes high-pitched croupy or whooping sound after he coughs.

## • **DIFFICULT OR RAPID BREATHING**

This is especially important in an infant under six months old.

## • **YELLOWISH SKIN OR EYES**

## • **PINKEYE**

Tears, redness of eyelid lining, irritation, followed by swelling and discharge of pus.

## • **UNUSUAL SPOTS OR RASHES**

## • **SORE THROAT OR TROUBLE SWALLOWING**

## • **INFECTED SKIN PATCH(ES)**

Crusty, bright yellow, dry or gummy areas of skin.

## • **UNUSUALLY DARK, TEA-COLORED URINE**

## • **GREY OR WHITE STOOL**

## • **HEADACHE AND STIFF NECK**

## • **VOMITING**

## • **UNUSUAL BEHAVIOR**

Child is cranky or less active than usual.  
Child cries more than usual. Child feels general discomfort or just seems unwell.

## • **LOSS OF APPETITE**

## • **SEVERE ITCHING OF BODY OR SCALP OR SCRATCHING OF THE SCALP**

(These may be signs of lice or scabies.)

The table below shows what you should do when a child has any of the symptoms listed above.

If a child in your center	Then
develops any of these symptoms of illness	Separate him from the other children and observe for other symptoms
appears feverish	Be sure a caregiver takes his temperature  Fever is 100°F (37.8°C) by oral thermometer and 101°F (38.3°C) by rectal thermometer  Temperature is taken rectally when a child is too young to use an oral thermometer without risk of injuring himself.
has ANY of the symptoms above marked with a star	Contact his parent(s) to have him picked up.
has a fever and any of the symptoms	Contact his parent(s) to have him picked up.
has any of the symptoms NOT marked by stars and is without fever	Contact his parent(s) to ask if they were aware of the symptom and to obtain any information they have about the child's condition or diagnosis.



# HEPATITIS B: PREVENTABLE AND MANAGEABLE

*Jerri Ann Jenista, M.D.  
Pediatric Infectious Disease  
Mott Children's Hospital, Ann Arbor*



I overheard one of the secretaries in the outer office answer the phone: "You wish to speak with Dr. Jenista? May I tell her what the phone call is about?" "Oh, a very confidential matter?" She then rang my office to announce: "Another worried parent calling about hepatitis B."

Hepatitis B is a virus infection of the liver. However, like AIDS or herpes, the social aspects of the infection are almost worse than the disease itself! Because hepatitis B is spread in some of the same ways as the AIDS virus, the two diseases are often linked in the minds of the public. Hepatitis B, however, is both preventable and manageable in the day care setting.

Strictly supervised or regimented time-limited activities such as Bible class, mother's play group, swimming or story hour incur no risk of transmission of hepatitis B. However, a day care home or center where children regularly eat, play, take naps, and are in prolonged contact with others of the same age group may pose a risk.

## **Who might have Hepatitis B in a Day Care setting?**

Usually, the concern in a day care focus on the hepatitis B chronic carrier. This person carries live infectious virus in his body and almost never shows any outward signs of the virus. Hepatitis B can only be diagnosed by blood tests.

Without realizing it, we all encounter hepatitis B carriers in our daily lives. However, the majority of carriers, especially children, are probably undiagnosed because hepatitis B testing is not a routine part of medical care in the United States.

## **How is Hepatitis B transmitted? Is there a possibility of transmission in day care?**

Hepatitis B is spread only through parenteral contact with blood or body secretions such as saliva or semen. "Parenteral" means the blood or secretion has to have some kind of contact with your blood stream. For example, you cannot contract hepatitis B by spilling infected blood or saliva on your intact skin. You can even safely swallow the blood or saliva. In order to contract hepatitis B, you have to have some opening to your blood stream available. So, if you spill infected blood onto a cut, if you cause some slight gum bleeding while sharing a toothbrush with a carrier, if a carrier child bites you to break the skin, or if you have sexual intercourse with a carrier, then you can contract the infection. Hepatitis B is also transmitted from mother to baby at birth.

It doesn't take a lot of imagination, given the above, to see how hepatitis B is transmitted within families even without dramatic exposure. When the carrier

child is a toddler, who knows how many times he has tried out every toothbrush in the bathroom? Or what about the cut finger he wiped off on your washcloth but never told you about because he wasn't supposed to touch dad's razor anyway? "Oh no," families tell me. "My children would never do such things." These are all "real life;" I've caught my kids at every one!

In a household, minute exposures to blood or saliva occur frequently. Clearly, the opportunity to transmit hepatitis B just does not exist in library story hour. Just as reasonably, a room with 10 three-year-olds and two caregivers will produce some, albeit rare, risky incidents.

The big question is, what is the cut-off between "no risk" and "some" or "high risk?" Unfortunately, no one really knows. There are very few day care studies on hepatitis B.

- In one day care center, an undiagnosed child carrier attended full-time for 17 months. No precautions were taken, and yet blood tests showed that no one became infected.
- In a day care home, a retarded child had extensive dental work with bleeding gums. Again, no precautions were taken since there was no suspicion of hepatitis B. His mother and the day care "mother" became infected but none of the other 12 children were affected.
- A four-year old with a bleeding skin disease was discovered to be a hepatitis B carrier. None of the 61 children or 24 staff at his day care center became infected.
- A child attending a 24-child classroom day care center became ill with hepatitis B. After extensive investigation, the Centers for Disease Control decided the only possible exposure was a carrier child at the day care. The particular child frequently bit and scratched. None of the other 40 persons in the day care acquired infection.

These data say to me; hepatitis B is not rampant in day care, even when there are no precautions taken and yet there is obvious blood exposure. A day care "home" may be more like a "real" home and thus may be more risky than other types of day care. If anyone is at risk, however, it seems to be the adult caregivers above all others.

## **What precautions should be taken with a known or suspected Hepatitis B carrier?**

Every day care setting must be evaluated individually. A well-supervised day care center practicing recommended standards for infection control will have no problems with hepatitis B. These standards include



such items as separate sinks for "washing up" and food preparation areas; cleaning and sanitizing changing areas before and after each child; frequent handwashing for adults and children. Signs of good infection control in a day care home would be such things as step stools, soap, and paper towels within easy access of children; toys that are clearly washable and washed frequently; uncrowded observable nap areas. While none of these are directed at hepatitis B prevention, day care with such careful attention to cleanliness is likely to be low risk for hepatitis B transmission.

Conversely, danger signals might be observations such as scratches or bite marks on children that the provider did not notice or has no explanation for; a kitchen counter used for diaper changes; a single cloth towel shared by everyone all day.

Obviously, any provider concerned about infection control will treat all blood and saliva exposures carefully. No specific measures for hepatitis B need to be taken. In this day and age of AIDS, I point out to providers that they have no idea who or what is coming through their day care. All body secretions should be treated appropriately at all times. Sharing food and kissing cuts "to make it all better" should be discouraged. This is what I want my own children to learn and I want it reinforced at day care just as it is at home.

## TAKE UNIVERSAL PRECAUTIONS

- Always treat blood as a potentially dangerous fluid.
- Place disposable items contaminated with blood or body fluid in plastic bags in covered containers.
- Sort clothing or other personal items stained with blood and/or secretions separately in a plastic bag to be sent home with the child for appropriate cleaning. Ask parents to wash and then **bleach** these articles.
- Clean surfaces or toys contaminated with blood or body fluids with the bleach solution as soon as possible after they are contaminated. You can also sanitize these articles by boiling them for 10 minutes.
- Use gloves when you clean up blood spills, especially if they are from a known hepatitis B carrier. **Wash your hands well afterward.**

Excerpted from *Healthy Young Children, A Manual for Programs*, NAEYC Publication, 1988.

The only occasions when a carrier child might be excluded from day care are situations such as:

- Unmanageable biting or scratching behavior
- Bleeding that cannot be controlled or covered with a bandage
- Extensive dental work that leads to a lot of bleeding or drooling

**Who should be informed about a carrier child in day care?**

This is a difficult question. Under most circum-

stances, I believe the day care provider should know of the child's status. Some infectious disease experts believe that in a well-supervised, infection-aware situation, notification need not necessarily be routine. This certainly may be true where children are older and have better hygienic behavior. Where there are young toddlers, or where an aggressive or biting child is included, I feel the day care provider should understand the carrier child's status.

Parents of other children, however, almost never need to be informed. The only exception might be if the other children exhibit consistently high risk behaviors, such as aggressive biting, not decreased by ordinary behavioral management ("time-out," etc.) In that situation, the biter provides risk to himself and others - and not just for hepatitis B.

### Who should be immunized?

Routine immunization against hepatitis B is not necessary in day care. Although the Centers for Disease Control are considering making hepatitis B one of the usual required "baby shots," the \$100 cost is sure to raise a lot of protest! Adult caregivers may want to consider getting vaccinated if the carrier child is very young or has abnormal behavior.

Almost never is it necessary to immunize the other children. Occasionally, another child may have a special risk himself, for example, a toddler with Down syndrome who may not have normal behavior and who also is at a higher risk of becoming a chronic carrier. Oftentimes, these special-risk children have already been immunized for other reasons.

If the hepatitis B vaccine were cheap, there would be no anxiety over transmission in day care. All children would be immunized and the problem would be solved. However, even if an accident should happen, for example, if the carrier child bit or was bitten drawing blood, the exposed child can be protected with an injection of hepatitis B immune globulin. Thus, a careful day care provider should not worry that she is exposing the non-carrier children to unnecessary risks.

### What about day care providers who are chronic carriers themselves?

The Centers for Disease Control do not place any occupational restrictions on hepatitis B carriers. Transmission from adults to children does not occur without intimate contact such as breast feeding or sexual relations. Any bleeding lesions should be covered, of course. Simple kissing and cuddling babies will not transmit the virus.

Hepatitis B in day care is not a rare situation. At least 800 new cases of hepatitis B are reported in Michigan each year. Some of those will be in children. Another 500 or so babies are born each year to carrier mothers in our state; many of those infants will be chronically infected. Should you be faced with these questions, your first approach should be to discuss the issues with your local health department. Most concerns can be resolved with just a simple understanding of the transmission of hepatitis B.

# A PRIMER ON HEPATITIS VIRUSES

Jerri Ann Jenista, M.D.

Hepatitis is any inflammation of the liver and can be caused by many things including virus infections, medication, alcohol abuse or industrial toxins. A doctor might suspect hepatitis in a person who complains of yellow eyes or skin, loss of appetite, extreme fatigue, fever, abdominal pain and dark urine.

The most frequent type of hepatitis found in day care is *hepatitis A*. This virus is spread through contact with stool or by contaminated water or food. Thus, it is common where there are many diapered children. Hepatitis A is usually asymptomatic, that is, without any signs or symptoms, in young children. The discovery of hepatitis A is almost always made when an adult caretaker comes down with the disease.

Epidemics of hepatitis A occur regularly in day care centers in Michigan; many more outbreaks are probably never recognized because the infection is so mild and is completely missed. Once hepatitis A is discovered in a day care setting, it is not difficult to contain. Local public health departments are well versed in hepatitis A control. Usually, careful attention to handwashing, diaper-changing and food preparation techniques is sufficient to eliminate spread of the virus. Complete recovery is the rule with hepatitis A. Hepatitis A generally produces no long-lasting liver damage; there is not chronic carrier state. Once past the infection, the person is not contagious.

*Hepatitis B* is much more difficult to transmit than hepatitis A. (see accompanying article). In the U.S., hepatitis B is found mainly in intravenous drug users, dialysis patients, persons who need frequent blood transfusions, homosexuals, prostitutes and babies of infected mothers. Persons who live or work in health care, prisons, or institutions for the mentally or

developmentally disabled are at higher risk of acquiring hepatitis B. Also, persons of Asian, sub-Saharan African, Alaskan Eskimo, Haitian or Pacific Island descent have a higher rate of hepatitis B infection even if they were born in this country.

Most children will have no signs of disease with hepatitis B. Some children and many adults, however, will be ill with jaundice (yellowing of the eyes and skin), fever, fatigue and belly pain. The illness may last several weeks.

Of each 200 cases of hepatitis B:

- 10 persons will be sick enough to be hospitalized.
- 1 person will die of liver failure.
- 10 persons will become chronic carriers of the virus.

Persons who are chronic carriers have the infectious virus in their bodies and may pass it on to others. Most carriers are not sick in any way themselves. This carrier state may last life-long. There is no treatment for hepatitis B but it can be prevented in two ways. There is a very safe and effective immunization given in three shots over six months. If an exposure to hepatitis B occurs in a non-immunized person, for example, by sexual intercourse with a chronic carrier, an injection of hepatitis B immune globulin (HBIG) can prevent the disease, even after the exposure.

*Delta hepatitis, non-A, non-B hepatitis and hepatitis C* are other virus infections that cause inflammation of the liver. We know very little about these viruses; some are just newly discovered. At present, these infections are usually diagnosed in adults with long-term or severe liver disease. They seem to be blood borne and are not thought to be very contagious. They are of no concern in the typical day care settings.





# NEW VACCINE SCHEDULE RECOMMENDED

David S. Olson, Pediatrician  
Grand Traverse Children's Clinic  
Traverse City

**Q: My pediatrician is recommending a new vaccine for my infant. Can you tell me about it?**

**A:** Your pediatrician is referring to a new use for an established vaccine. Recently the American Academy of Pediatrics recommended that one of the Hemophilus influenzae type b conjugate vaccines (HbOC) be given at 2, 4, 6 and 15 months of age. This vaccine previously had been recommended at only 15 months of age.

The vaccine offers protection against Hemophilus influenzae type b (Hib), a bacteria that is the leading cause of meningitis—an infection of the covering of the brain—in children under the age of five. Of note, this bacteria does not cause influenza, which is a respiratory illness caused by a virus.

About 1 in 20 children with Hib meningitis die, and 1 in 4 have permanent brain damage, despite vigorous treatment with antibiotics. About 20,000 cases of Hib disease occur annually and over half of those include meningitis. The bacteria also causes pneumonia and infections of the blood, joints, throat and skin.

**Q: How effective is the vaccine?**

**A:** The vaccine produces protective antibody levels

in young infants using the four-dose schedule. Based on studies in the United States and Europe, the vaccine could potentially prevent 80 percent, or 16,000 cases, of Hib disease annually.

**Q: I worry about the side effects of vaccines. Is this vaccine safe?**

**A:** The HbOC vaccine is remarkably safe. The side effects are transient and mild. About two percent of infants will have a low fever within 24 hours of the injection. An equal percent will have some redness at the injection site.

**Q: How can I obtain the vaccine for my infant?**

**A:** Currently, this vaccine is available in physicians' offices. The vaccine is given to children at the public health department only at 15 months of age; however, the health department may give the vaccination at earlier ages in the future. Check with your local health department about availability of this vaccine.

Please contact your child's physician regarding additional information about the HbOC vaccine.

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## VACCINE PREVENTABLE DISEASE

Many infectious diseases cause the body to produce disease fighting substances—antibodies—which later protect against future invasions by the same virus or bacteria. Vaccines have been made for some of these diseases by changing the germ or by inactivating the poisons produced by the germ. Small amounts of these vaccines are then injected or taken by mouth causing a very mild and often inapparent illness which in turn causes a large quantity of antibodies to be made.

Some vaccines are so effective and the diseases they prevent are so serious that immunization has become a standard practice. To help make sure that all children get this protection, laws in all states now require schools and day care centers to check each child as he enrolls to insure that his immunization record is on file and is appropriate for his age. For most children, a series of vaccinations is given including four DTP (diphtheria, tetanus and pertussis) three polio and one MMR (measles, mumps and rubella).

Excerpted from *Communicable Disease in Child Care Settings*, Michigan Department of Social Service and Michigan Department of Public Health, Pub. 111.

### American Academy of Pediatrics recommended vaccine schedule

Vaccine	2 mos.	4 mos.	6 mos.	15 mos.	18 mos.	5-6 yrs.
Diphtheria/ Pertussis/ Tetanus	✓	✓	✓		✓	✓
Oral polio	✓	✓			✓	✓
Measles/ Mumps/ Rubella				✓		
Hemophilus/ Influenza/ Type B conjugate	✓		✓	✓		

A booster shot for measles/mumps/rubella can be given either at 5-6 years or around 12 years, depending upon your doctor's preference. Vaccine for adult tetanus/diphtheria can be given at 15 years.

# ASK DR. SUE

Susan S. Aronson, M.D.  
Clinical Professor of Pediatrics  
Hahnemann University, Philadelphia, PA

**QUESTION:** *What is Fifth Disease? What do we need to do about it in child care?*

**ANSWER:** Fifth Disease is an infection caused by virus (parvovirus B19) that infects only humans and is transmitted by respiratory secretions. The illness may include fever for up to seven days, followed after another week by a distinctive rash on the face, body, and limbs. The disease is called *Slapped Cheek Syndrome* because the rash on the face resembles someone who has just been slapped. The rash on the body is pink and lacy looking. Adults who become infected with the virus may also develop joint pain and/or swelling with the rash, but the illness is most often recognized in young children. As with so many other viruses, this infection occurs most of the time without any symptoms and is most contagious for the week before the rash appears in those who get symptoms. By the time the rash is seen, little or no virus is being shed by the infected person.

Epidemics of Fifth Disease start in late winter and last for two to six months, but the disease can occur at any time of year. The reason the disease is seen less often in adults is that by adulthood, about half of adults have already been infected and are immune to the virus. Only 5 to 10 percent of preschoolers have already had the infection, so they provide a fertile ground for the spread of the virus. Close contact such as that found in families and early childhood programs enhances the spread of the virus.

Aside from causing a mild, inconvenient illness, parvovirus B19 is important because it is yet another virus that can cause harm to the fetus of a pregnant

woman who first becomes infected by it during her pregnancy. A small percentage of pregnant women (three to nine percent) who are infected in the first few weeks of pregnancy can cause fetal anemia and death of the baby. Blood tests to detect immunity to parvovirus B19 are possible but are not widely available.

Based on the information currently available about Fifth Disease and the virus that causes it, the following recommendations are appropriate for early childhood programs:

- Exclusion of children with Fifth Disease is not necessary.
- Pregnant women who are working in early childhood settings need to know that there is an increased risk of exposure to the parvovirus B19 as well as other viruses that can potentially cause harm to their fetuses. However, previous infection makes many women immune and, even with first-time infection pregnancy, fetal illness is uncommon. Therefore, the risk of fetal illness is very small (much less than one percent).
- The risk of spread of parvovirus B19 can be decreased by using tissues to wipe runny noses, properly disposing of tissues that contain respiratory secretions, and most important of all, hand washing after contact with body fluids. The best way to dispose of contaminated material is to put it into a plastic-lined step can (a can with a lid that is operated by a foot pedal).

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# SIDS (Sudden Infant Death Syndrome)

*Judy Kulka, Nursing Supervisor  
Ingham County Health Department*

Although in recent years SIDS information has appeared in the media and in popular journals, recently there have been situations that would indicate there is still an absence of knowledge about SIDS in the general population.

SIDS stands for "Sudden Infant Death Syndrome." It is the diagnosis ascribed to infant death when no cause can be determined. Other terms for this syndrome are "crib death" or "cot death."

Infants who die of SIDS are usually two to four months of age. They appear to be normal healthy infants with no indication of any kind of problem. Some may have had signs of a slight cold, but autopsies show nothing that would account for the infant's death.

Over 6,000 infants die of SIDS each year in the United States. It is not known why these deaths happen. Recent research shows that SIDS cannot be prevented. The cause of death is not suffocation or choking.

Any adult caring for the infant at the time of death feels responsible for the infant's death. Even worse, the caregiver may be blamed even though there is nothing she could have done to prevent the death. SIDS can occur to any infant, even to one receiving the most competent and loving care possible.

When a SIDS infant is found dead, the caregiver's first thought is to call an emergency service, such as 911 or an EMT service. The emergency service's first action will be to try to resuscitate the infant and transport him to a hospital emergency room where a physician will pronounce the death. A representative of the County Medical Examiner's office will be called to investigate the circumstances around the death and authorize an autopsy, since SIDS is an unexpected death. In Michigan there is no charge to the family for the autopsy. There may also be a police department investigation.

It is important that parents and day care providers not blame each other in cases of SIDS death, whether the death occurred at the infant's home or the day care site, or at any other place in the community. There have been cases of SIDS infants dying in a stroller in a store in the care of a parent, a car seat while traveling out of state with the parents, as well as most commonly in a crib or in a bed with a parent.

In most areas of Michigan there is a support group available for persons who have lost an infant to SIDS. The National Sudden Infant Death Syndrome Foundation, Inc. (1-800-221-SIDS) or your local health department can provide information about the location and meeting times of the closest support group.

In cases of infants who were in a day care situation, the parent(s) and day care provider may attend support group meetings together. Sometimes grandparents of the infant or other close friends also attend.

Older children who knew the infant may be very disturbed by the infant's death and concerned they may die like the infant died.

They should be told that only a few infants die of SIDS, and the SIDS deaths only occur in infants less than one year of age.

Sometimes children may think the thoughts they had about the infant caused its death and they may feel very guilty. They should be told as much about the facts as they are able to understand and be shown love and affection.

Anyone experiencing a severe grief reaction to the SIDS death may benefit from specialized grief counseling. Counseling resources are available from the Community Mental Health agency in one's area.

It is possible that people not informed about SIDS may say insensitive things to the parents or caregiver of the infant. Just know that SIDS is no one's fault — the cause is at present unknown. Literature is available from the National Sudden Infant Death Syndrome Foundation office, 10500 Little Patuxent Pkwy. Suite 420, Columbia, MD 21044 (1-800-221-SIDS) or from your local health department.

## **Michigan Association for the Education of Young Children**

### **Child Development Conference**

*February 28- March 2, 1991  
Amway Grand Plaza Hotel  
Grand Rapids*

# DIAPERING IN DAY CARE

Elaine Reinmuth  
Pediatric Nurse Practitioner  
Washtenaw County Health Department

The way that diapering is done in a day care can help prevent the spread of diseases such as diarrhea, vomiting, and more serious intestinal infections from salmonella, shigella, giardia as well as hepatitis A. Correct diaper changing techniques, handling of dirty diapers, cleaning the diaper changing area and hand-



washing can control the spread of disease among infants and toddlers.

The following are Public Health's recommendations for diapering in day care:

## CHANGING AREA

1. The diaper changing area should be away from the food handling area. A different sink should be used for diapering/toileting from food preparation.
2. All diapering is done on a surface with a washable plastic-covered pad with no cracks or tears.
3. Disposable paper should cover the plastic surface so that each child lies on a fresh, clean surface. Shelf paper, wax paper, scrap computer paper or cut-up bags may be used.

## DIAPERING PROCEDURE

1. Get out all materials needed before you begin — clean diaper, wet paper towel or wipe, plastic bag and clean clothes if necessary.
2. Cover the plastic changing pad with a fresh piece of disposable paper.
3. Put the child on the paper surface and remove dirty diaper.
4. Clean child with paper towel or a wipe. Rediaper the child.

5. Roll up the soiled diaper in the disposable paper that was under the child and discard into a covered waste can with a plastic liner, preferably a can with a foot pedal.
6. Put any soiled clothing in a plastic bag. Never rinse out a soiled diaper.
7. Clean the plastic surface every time feces or urine leaks on it. Wash with detergent and sanitize with a chlorine bleach solution of  $\frac{1}{4}$  cup bleach to 1 gallon water. The sanitizing solution can be wiped or sprayed on and allowed to air dry. It is important to mix a new solution of bleach and water daily. The solution loses its potency after a day. It should be labeled and stored out of the reach of children. If you have questions contact your local Health Department.

## WASH HANDS THOROUGHLY!

8. Use soap and warm running water. Dry with a paper towel. Then use the paper towel to turn off the faucets.
9. The diapering area, pad, table, and all containers of wipes, lotions, powder, etc. should be sanitized with a disinfectant if there are specific diapering times and regularly at the end of the day.
10. Dispose of the plastic bag with dirty diapers when full and at least daily.
11. Clean and disinfect the diaper waste can weekly.

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Please send articles for consideration in future issues to:

Better Homes and Centers  
Div. of Child Day Care Licensing  
Ingham County Dept. of Social Services  
5303 S. Cedar St.  
Lansing, Michigan 48911

## EDITORIAL STAFF

Tina Marks	Home Licensing Consultant
Sue Young	Home Licensing Consultant
Sandra Settergren	Home Licensing Consultant
Carole Grates	Center Licensing Consultant
Patricia Hearron	Center Licensing Consultant
Judy Levine	Licensing Supervisor
Sheila Linderman	Illustrator

## RESOURCES: HEALTH PRACTICES

For information on various contagious diseases contact your Local Public Health Departments.

For information on Hepatitis B contact  
Jerri Ann Jenista, M.D.  
University of Michigan Medical Center  
Pediatrics Infectious Disease  
F2438/0244, C.S. Mott Children's Hospital  
Ann Arbor, MI 48109-0244  
313-763-2440

Dennis Murray, M.D.  
Michigan State University  
Pediatric Infectious Disease  
240 Life Science Building  
East Lansing, MI 48824  
517-353-7806

Finally, the Centers for Disease Control (Atlanta, GA) also maintains a 24-hour-a-day hepatitis hotline: 404-332-4555.

Andersen, R.D., Bale, J.F., Blackman, J.A. and Murph, J.R. *Infections in Children: A Resource Book for Educators and Child Care Providers*. Rockville, MD: Aspen. (1986)

California State Department of Education: *Techniques for Preventing the Spread of Infectious Diseases*. Sacramento, CA. (1983). There is a small fee for this and other relevant publications: California State Department of Education P.O. Box 271, Sacramento, CA 95802.

Michigan Department of Social Services and Michigan Department of Public Health. *Communicable Disease in Child Care Settings*. DSS. Pub. 111. Pamphlet.

Pokorni, J.L. and Kaufmann, R.K. *Health in Day Care: A Training Guide for Day Care Providers*. Washington D.C. Georgetown University Child Development Center (1986). An accompanying manual, *Health in Day Care: A Manual in Day Care Providers*, can be obtained from the same source. Order manuals from: Georgetown University Child Development Center, 3800 Reservoir Road, NW, Washington, DC 20007, (202) 687-8635.

Sleator, E.K. *Infectious Diseases in Day Care*. Urbana, IL: Clearinghouse on Elementary and Early Childhood Education, University of Illinois (1983).

Taylor, Janeen McCracken, Ph.D., and Taylor W. Scott, M.D., *Communicable Disease and Young Children in Group Settings*. College — Hill Press (1989).

## PROVIDER'S CORNER



Three new grant programs have been developed by the Michigan Department of Commerce for employer-sponsored child care. These programs resulted from recommendations of former Governor Blanchard's "Michigan Child Care Partnership," a task force which investigated ways to facilitate employer-sponsored child care.

The overall program objective is to increase Michigan's supply of quality child care by facilitating employers' and child care providers' efforts to help Michigan's working families balance the often-conflicting demands of work and family.

A premise of the program is that the availability of quality, affordable child care can affect absenteeism, tardiness, public image, employee morale, productivity, and ultimately, the "bottom-line." For this reason, child care has become an economic, rather than a family issue, having impact on our state's ability to recruit and retain a competitive workforce.

The grants will be awarded on a competitive basis. There will be two dispersal periods, February and June 1991. The purpose of this article is to inform you of these grants so that you can begin to prepare any projects which may qualify for funding. For more information and to receive an application packet, please call the hotline for the new Michigan Child Care Clearinghouse: Options for Progressive Employers, 1-800-421-3225, or write:

The Michigan Child Care Clearinghouse  
P.O. Box 30004  
Lansing, Michigan 48909

### In Memory

This issue is dedicated to the memory of Jaqueline Miller and Jim Fennimore.

Jacki was the owner of a child care center in Ann Arbor. She was the past president of the Michigan Association for the Education of Young Children and continued in her advocacy role to the end.

Jim was a center licensing consultant in the Ann Arbor area for the last 15 years. He tirelessly advocated on behalf of Michigan's young children and the centers with whom he worked.

We are all better off for having known them. Now we must all strive to continue their efforts.





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